Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

VISTA HOSPITAL OF DALLAS
4301 VISTA RD
PASADENA TX 77504-2117

Respondent Name
AMERICAN CASUALTY CO OF READING PA

Carrier's Austin Representative Box
Box Number 47

MFDR Tracking Number
M4-09-A033-01

MFDR Date Received
July 3, 2009

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Provider submitted an erroneously marked bill requesting 'Separate Reimbursement to Hospital for Implantables Requested.' We are not requesting separate reimbursement for implants."

Amount in Dispute: $3,759.78

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Provider did not state in its request for reconsideration that the 200% payment adjustment factor applies in this case, rather than the 130% payment adjustment factor, because it erroneously requested separate reimbursement for implants. On the contrary, Provider stated that it was 'requesting the additional reimbursement of $3,765.58 for **Implant Reimbursement**' and provided an explanation of how implants are to be reimbursed under the fee guideline."

Response Submitted by: Stone Loughlin & Swanson, LLP, 3508 Far West Boulevard, Suite 200, Austin, Texas 78731

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
July 7, 2008	Outpatient Hospital Services	$3,759.78	$3,579.78

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403, titled *Hospital Facility Fee Guideline – Outpatient*, sets out the reimbursement guidelines for facility services provided in an outpatient acute care hospital.
3. 28 Texas Administrative Code §134.203, titled *Medical Fee Guideline for Professional Services*, sets out the reimbursement guidelines for professional medical services.

4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 58 – Treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service.
   - (729-001) – THIS SERVICE IS NOT REIMBURSABLE IN A HOSPITAL OUTPATIENT SETTING.
   - 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.
   - (243) – THIS PROCEDURE HAS BEEN INCLUDED IN ANOTHER PROCEDURE PERFORMED ON THE SAME DAY.
   - W1 – Workers Compensation State Fee Schedule Adjustment
   - (595-001) – THE REIMBURSEMENT AMOUNT IS BASED ON THE MEDICARE REIMBURSEMENT PLUS THE PERCENTAGE INCREASE SPECIFIED BY THE STATE.

Issues

1. Are the disputed services subject to a contractual agreement between the parties to this dispute?
2. What is the applicable rule for determining reimbursement for the disputed services?
3. What is the recommended payment amount for the services in dispute?
4. What is the additional recommended payment for the implantable items in dispute?
5. Is the requestor entitled to reimbursement?

Findings

1. Review of the submitted documentation finds no information to support that the disputed services are subject to a contractual agreement between the parties to this dispute.
2. This dispute relates to facility services performed in an outpatient hospital setting with reimbursement subject to the provisions of 28 Texas Administrative Code §134.403, which requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (MAR) shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register with the application of minimal modifications as set forth in the rule. Review of the submitted medical bill finds that separate reimbursement for implantables was requested. The requestor's position statement asserts that "Provider submitted an erroneously marked bill requesting 'Separate Reimbursement to Hospital for Implantables Requested.' We are not requesting separate reimbursement for implants." The respondent's position statement asserts that "Provider did not state in its request for reconsideration that the 200% payment adjustment factor applies in this case, rather than the 130% payment adjustment factor. . . . On the contrary, Provider stated that it was 'requesting the additional reimbursement of $3,765.58 for **Implant Reimbursement**' and provided an explanation of how implants are to be reimbursed under the fee guideline." Review of the request for reconsideration finds that the bill for the disputed services is stamped "SEPARATE REIMBURSEMENT TO HOSPITAL FOR IMPLANTABLES REQUESTED." The Division concludes that the facility requested separate reimbursement for implantables. Therefore, per §134.403(f)(1)(B), the facility specific reimbursement amount including outlier payments is multiplied by 130 percent. Per §134.403(f)(2), when calculating outlier payment amounts, the facility's total billed charges shall be reduced by the facility's billed charges for any item reimbursed separately under §134.403(g). The facility's total billed charges for the separately reimbursed implantable items are $4,250.00. Accordingly, the facility's total billed charges shall be reduced by this amount for the purpose of calculating any outlier payments below.
3. Under the Medicare Outpatient Prospective Payment System (OPPS), each billed service is assigned an Ambulatory Payment Classification (APC) based on the procedure code used, the supporting documentation and the other services that appear on the bill. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC per encounter. Payment for ancillary and supportive items and services, including services that are billed without procedure codes, is packaged into payment for the primary service. A full list of APCs is published quarterly in the OPPS final rules which are publicly available through the Centers for Medicare and Medicaid Services (CMS) website. Reimbursement for the disputed services is calculated as follows:
   - Procedure code A4215 has a status indicator of E, which denotes non-covered items, codes or services that are not paid by Medicare when submitted on outpatient claims. Reimbursement is not recommended.
   - Procedure code 85014 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $3.31. 125% of this amount is $4.14

- Procedure code 73030 has a status indicator of X, which denotes ancillary services paid under OPPS with separate APC payment. These services are classified under APC 260, which, per OPPS Addendum A, has a payment rate of $44.29. This amount multiplied by 60% yields an unadjusted labor-related amount of $26.57. This amount multiplied by the annual wage index for this facility of 0.9786 yields an adjusted labor-related amount of $26.00. The non-labor related portion is 40% of the APC rate or $17.72. The sum of the labor and non-labor related amounts is $43.72. The cost of these services does not exceed the annual fixed-dollar threshold of $1,575. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line is $43.72. This amount multiplied by 130% yields a MAR of $56.84.
- Procedure code Q0092 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code 29827 has a status indicator of T, which denotes a significant procedure subject to multiple-procedure discounting. The highest paying status T procedure is paid at 100%; all others are paid at 50%. This procedure is paid at 100%. These services are classified under APC 42, which, per OPPS Addendum A, has a payment rate of $2,911.27. This amount multiplied by 60% yields an unadjusted labor-related amount of $1,746.76. This amount multiplied by the annual wage index for this facility of 0.9786 yields an adjusted labor-related amount of $1,709.38. The non-labor related portion is 40% of the APC rate or $1,164.51. The sum of the labor and non-labor related amounts is $2,873.89. Per Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, if a claim has more than one surgical service line with a status indicator of S or T and any of those lines has a charge of less than $1.01, then the charges for all S and T lines are summed and the charges are divided across those lines in proportion to their APC payment rate. The new charge amount is used in place of the submitted charge amount in the line-item outlier calculation. This claim has a status indicator S or T line item with a billed charge less than $1.01; therefore, all S and T line charges are reallocated accordingly. The APC payment for this service of $2,873.89 divided by the sum of all S and T APC payments of $5,890.09 gives an APC payment ratio for this line of 0.48792, multiplied by the sum of all S and T line charges of $11,184.00, yields a new charge amount of $5,456.90 for the purpose of outlier calculation. Per 42 Code of Federal Regulations §419.43(d) and Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, if the total cost for a service exceeds 1.75 times the OPPS payment and also exceeds the annual fixed-dollar threshold of $1,575, the outlier payment is 50% of the amount by which the cost exceeds 1.75 times the OPPS payment. Per the OPPS Facility-Specific Impacts file, CMS lists the cost-to-charge ratio for this provider as 0.326. This ratio multiplied by the billed charge of $5,456.90 yields a cost of $1,778.95. The total cost of all packaged items is allocated proportionately across all separately paid OPPS services based on the percentage of the total APC payment. The APC payment for these services of $2,873.89 divided by the sum of all APC payments is 48.14%. The sum of all packaged costs is $14,841.46. The allocated portion of packaged costs is $7,145.10. This amount added to the service cost yields a total cost of $8,924.05. The cost of these services exceeds the annual fixed-dollar threshold of $1,575. The amount by which the cost exceeds 1.75 times the OPPS payment is $3,894.74. 50% of this amount is $1,947.37. The total Medicare facility specific reimbursement amount for this line, including outlier payment, is $4,821.26. This amount multiplied by 130% yields a MAR of $6,267.64.
- Procedure code 29823 has a status indicator of T, which denotes a significant procedure subject to multiple-procedure discounting. The highest paying status T procedure is paid at 100%; all others are paid at 50%. This procedure is paid at 50%. These services are classified under APC 42, which, per OPPS Addendum A, has a payment rate of $2,911.27. This amount multiplied by 60% yields an unadjusted labor-related amount of $1,746.76. This amount multiplied by the annual wage index for this facility of 0.9786 yields an adjusted labor-related amount of $1,709.38. The non-labor related portion is 40% of the APC rate or $1,164.51. The sum of the labor and non-labor related amounts is $2,873.89. Per Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, if a claim has more than one surgical service line with a status indicator of S or T and any of those lines has a charge of less than $1.01, then the charges for all S and T lines are summed and the charges are divided across those lines in proportion to their APC payment rate. The new charge amount is used in place of the submitted charge amount in the line-item outlier calculation. This claim has a status indicator S or T line item with a billed charge less than $1.01; therefore, all S and T line charges are reallocated accordingly. The APC payment for this service of $1,436.95 divided by the sum of all S and T APC payments of $5,890.09 gives an APC payment ratio for this line of 0.243961, multiplied by the sum of all S and T line charges of $11,184.00, yields a new charge amount of $2,728.46 for the purpose of outlier calculation. Per 42 Code of Federal Regulations §419.43(d) and Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, if the total cost for a service exceeds 1.75 times the OPPS payment and also exceeds the annual fixed-dollar threshold of $1,575, the outlier payment is 50% of the amount by which the cost exceeds 1.75 times the OPPS payment. Per the OPPS Facility-Specific Impacts file, CMS lists the cost-to-charge ratio for this provider as 0.326. This ratio multiplied by the billed charge of $2,728.46 yields a cost of $889.48. The total cost of all packaged items is allocated proportionately across all separately paid OPPS services based on the percentage of the total APC payment. The APC payment for these services of $1,436.95 divided by the sum of all APC payments is 24.07%. The sum of all packaged costs is $14,841.46. The allocated portion of packaged costs is $3,572.56. This amount added to the service cost yields a total cost

of $4,462.04. The cost of these services exceeds the annual fixed-dollar threshold of $1,575. The amount by which the cost exceeds 1.75 times the OPPS payment is $1,947.38. 50% of this amount is $973.69. The total Medicare facility specific reimbursement amount for this line, including outlier payment and multiple-procedure discount, is $2,410.64. This amount multiplied by 130% yields a MAR of $3,133.84.

- Procedure code 29826 has a status indicator of T, which denotes a significant procedure subject to multiple-procedure discounting. The highest paying status T procedure is paid at 100%; all others are paid at 50%. This procedure is paid at 50%. These services are classified under APC 42, which, per OPPS Addendum A, has a payment rate of $2,911.27. This amount multiplied by 60% yields an unadjusted labor-related amount of $1,746.76. This amount multiplied by the annual wage index for this facility of 0.9786 yields an adjusted labor-related amount of $1,709.38. The non-labor related portion is 40% of the APC rate or $1,164.51. The sum of the labor and non-labor related amounts is $2,873.89. Per Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, if a claim has more than one surgical service line with a status indicator of S or T and any of those lines has a charge of less than $1.01, then the charges for all S and T lines are summed and the charges are divided across those lines in proportion to their APC payment rate. The new charge amount is used in place of the submitted charge amount in the line-item outlier calculation. This claim has a status indicator S or T line item with a billed charge less than $1.01; therefore, all S and T line charges are reallocated accordingly. The APC payment for this service of $1,436.95 divided by the sum of all S and T APC payments of $5,890.09 gives an APC payment ratio for this line of 0.243961, multiplied by the sum of all S and T line charges of $11,184.00, yields a new charge amount of $2,728.46 for the purpose of outlier calculation. Per 42 Code of Federal Regulations §419.43(d) and Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, if the total cost for a service exceeds 1.75 times the OPPS payment and also exceeds the annual fixed-dollar threshold of $1,575, the outlier payment is 50% of the amount by which the cost exceeds 1.75 times the OPPS payment. Per the OPPS Facility-Specific Impacts file, CMS lists the cost-to-charge ratio for this provider as 0.326. This ratio multiplied by the billed charge of $2,728.46 yields a cost of $889.48. The total cost of all packaged items is allocated proportionately across all separately paid OPPS services based on the percentage of the total APC payment. The APC payment for these services of $1,436.95 divided by the sum of all APC payments is 24.07%. The sum of all packaged costs is $14,841.46. The allocated portion of packaged costs is $3,572.56. This amount added to the service cost yields a total cost of $4,462.04. The cost of these services exceeds the annual fixed-dollar threshold of $1,575. The amount by which the cost exceeds 1.75 times the OPPS payment is $1,947.38. 50% of this amount is $973.69. The total Medicare facility specific reimbursement amount for this line, including outlier payment and multiple-procedure discount, is $2,410.64. This amount multiplied by 130% yields a MAR of $3,133.84.
- Procedure code 20926 has a status indicator of T, which denotes a significant procedure subject to multiple-procedure discounting. The highest paying status T procedure is paid at 100%; all others are paid at 50%. This procedure is paid at 50%. These services are classified under APC 135, which, per OPPS Addendum A, has a payment rate of $288.30. This amount multiplied by 60% yields an unadjusted labor-related amount of $172.98. This amount multiplied by the annual wage index for this facility of 0.9786 yields an adjusted labor-related amount of $169.28. The non-labor related portion is 40% of the APC rate or $115.32. The sum of the labor and non-labor related amounts is $284.60. Per Medicare Claims Processing Manual, CMS Publication 100-04, Chapter 4, §10.7.1, if a claim has more than one surgical service line with a status indicator of S or T and any of those lines has a charge of less than $1.01, then the charges for all S and T lines are summed and the charges are divided across those lines in proportion to their APC payment rate. The new charge amount is used in place of the submitted charge amount in the line-item outlier calculation. This claim has a status indicator S or T line item with a billed charge less than $1.01; therefore, all S and T line charges are reallocated accordingly. The APC payment for this service of $142.30 divided by the sum of all S and T APC payments of $5,890.09 gives an APC payment ratio for this line of 0.024159, multiplied by the sum of all S and T line charges of $11,184.00, yields a new charge amount of $270.19 for the purpose of outlier calculation. The cost of these services does not exceed the annual fixed-dollar threshold of $1,575. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line, including multiple-procedure discount, is $142.30. This amount multiplied by 130% yields a MAR of $184.99.
- Procedure code 99144 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Per Medicare policy, procedure code 94762 may not be reported with procedure code 99144 billed on the same claim. Payment for this service is included in the payment for the primary procedure. Separate payment is not recommended.
- Procedure code 94760 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code 94799, date of service July 8, 2008, has a status indicator of X, which denotes ancillary services paid under OPPS with separate APC payment. The provider billed this procedure code with 5 units; however, review of the submitted documentation finds that only 1 unit is supported. Therefore, only 1 unit can be considered for payment. These services are classified under APC 367, which, per OPPS Addendum A, has

a payment rate of $36.16. This amount multiplied by 60% yields an unadjusted labor-related amount of $21.70. This amount multiplied by the annual wage index for this facility of 0.9786 yields an adjusted labor-related amount of $21.24. The non-labor related portion is 40% of the APC rate or $14.46. The sum of the labor and non-labor related amounts is $35.70. The cost of these services does not exceed the annual fixed-dollar threshold of $1,575. The outlier payment amount is $0. The total Medicare facility specific reimbursement amount for this line is $35.70. This amount multiplied by 130% yields a MAR of $46.41.

- Per Medicare policy, procedure code 99205 may not be reported with procedure code 99144 billed on the same claim. Payment for this service is included in the payment for the primary procedure. Separate payment is not recommended.
- Procedure code G0378 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.
- Procedure code G0378, date of service July 8, 2008, has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into the reimbursement for other services, including outliers.

4. Additionally, the provider requested separate reimbursement of implantables. Per §134.403(g), "Implantables, when billed separately by the facility or a surgical implant provider in accordance with subsection (f)(1)(B) of this section, shall be reimbursed at the lesser of the manufacturer's invoice amount or the net amount (exclusive of rebates and discounts) plus 10 percent or $1,000 per billed item add-on, whichever is less, but not to exceed $2,000 in add-on's per admission." Review of the submitted documentation finds that the separate implantables include:
   - "CENTRIFUGE SEPARATOR" as identified in the itemized statement and labeled on the invoice as "PRP Cetrifuge and Cell Separator" with a cost per unit of $850.00.

   The total net invoice amount (exclusive of rebates and discounts) is $850.00. The total add-on amount of 10% or $1,000 per billed item add-on, whichever is less, but not to exceed $2,000 in add-on's per admission is $85.00. The total recommended reimbursement amount for the implantable items is $935.00.
5. The total allowable reimbursement for the services in dispute is $13,762.68. The amount previously paid by the insurance carrier is $8,020.36. The requestor is seeking additional reimbursement in the amount of $3,579.78. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $3,579.78.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $3,579.78, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Grayson Richardson	June 14, 2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.